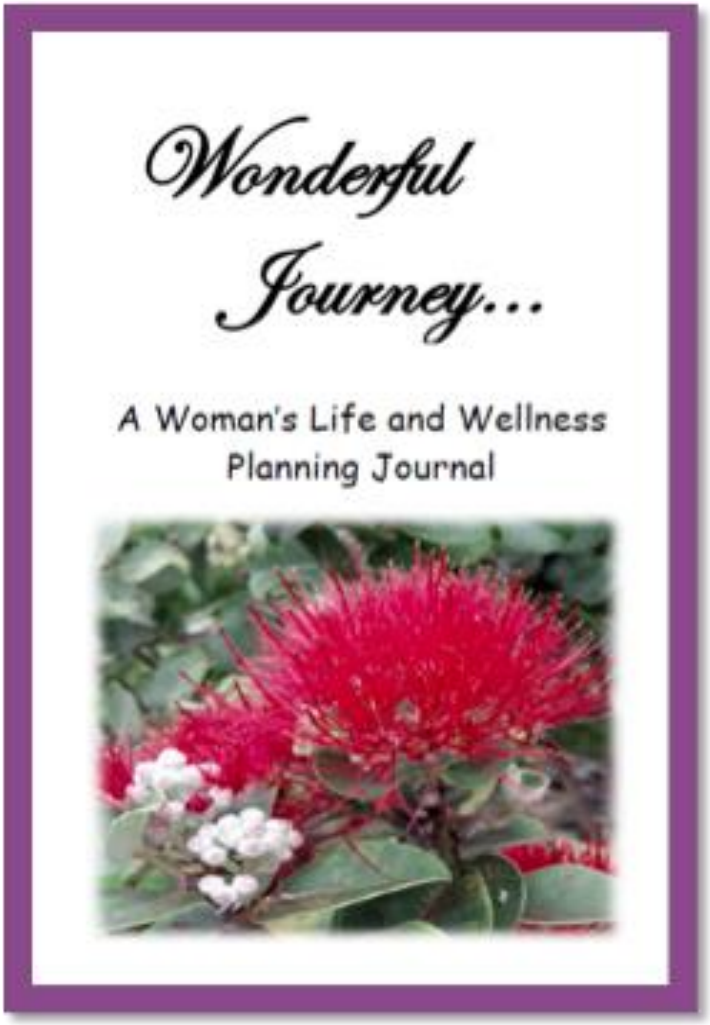
**Wonderful Journey...A Woman's Wellness and Life Planning Journal**
**Evaluation Report**

January 23, 2015

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## Executive Summary

Forty-five percent of pregnancies in the State of Hawai'i are unintended. Vulnerable populations are disproportionately at risk, which poses economic and social implications for the state and its residents. Culturally appropriate programs can help to combat this adverse health outcome, and meet the goals of the 2010 Title V Maternal and Child Health Needs Assessment (State of Hawai'i DOH, 2010). The CDC recommends that all women of reproductive age (15-44 years) create a reproductive life plan (RLP) as a strategy to increase planned pregnancies (Johnson et al., 2006). However, only 23% of women receiving care from Title X clinics developed an RLP during their last visit (D. Hayes, personal communication). To ameliorate these disparities, the MCHB will implement and evaluate the *Wonderful Journey… A Woman's Life and Wellness Planning Journal* booklet in clinics receiving Title X federal funding.

This report describes a formative evaluation to be conducted by the MCHB during the first year of booklet implementation, in order to understand how the booklet is delivered in practice and demonstrate intervention effectiveness. Evaluation activities include: (1) pilot testing with the target population; (2) ongoing technical assistance and staff log; (3) booklet distribution tracking log in Title X clinics; (4) user testing; (5) linkage of the distribution log to the Title X Client Visit Record to evaluate associations between booklet use and RLP creation.

The formative evaluation will employ a quasi-experimental study design with a mixed-methods convergent parallel approach for data collection, management, and analysis. We recommend both consensual qualitative analysis, as well as univariate and bivariate approaches for quantitative assessment. Using findings from stakeholder interviews, we detail recommendations for booklet improvement, implementation, and evaluation. We describe our underlying assumptions and potential limitations to the proposed evaluation and opportunities for stakeholder engagement.

## Background: Key demographics and Title X services in the State of Hawai'i

The State of Hawai'i is composed of seven inhabited islands within four counties with an estimated population of 1.4 million in 2013 (U.S. Census Bureau, 2014). The City and County of Honolulu encompasses the entire island of Oahu, containing the majority of the population, and the only urban area in the state. The neighbor island counties are Hawai'i, Kauai (including Niihau island), and Maui (including Molokai, Lanai, and Kahoolawe).

There are a number of demographic and geographical factors which present unique challenges and opportunities for the Department of Health (DOH) in program implementation and evaluation. First, the geography and distance of the islands have a significant impact on residents' access to services. For example, given that Oahu is the only urban island, it houses the majority of tertiary healthcare facilities and birthing hospitals, including the one perinatal Level III facility in the state (State of Hawai'i DOH, 2010). Second, the racial/ethnic composition of Hawai'i varies significantly from national figures. There is no majority population in the state, with a large proportion of Asian individuals (37.7% v. 5.3% nationally), Native Hawaiian and Other Pacific Islander (10% v. 0.2%) and those who report belong to more than one racial group (23.1% v. 2.4%) (U.S. Census Bureau, 2014). Further, Hawai'i is a gateway to the U.S. for immigrants from Asia and the Pacific: 17.9% of individuals living in Hawai'i are foreign born, many hailing from this region (U.S. Census Bureau, 2014). Third, Native Hawaiians are

considered among the state's most vulnerable group with respect to health and economic measures (U.S. Census Bureau, 2012). Hawai'i County is rural, with the highest rates of poverty and largest Native Hawaiian population in the state (State of Hawai'i DOH, 2010). Finally, indicators of socioeconomic disadvantage abound: 16% of adults in Hawai'i lack basic literacy skills (U.S. Department of Education, 2003), 11.2% of the population live below the federal poverty line (U.S. Census Bureau, 2014), with significant differences in poverty rates by county and race/ethnicity (State of Hawai'i DOH, 2010).

The Family Health Services Division (FHSD) of the DOH is the chief architect and funder of maternal and child health (MCH) programs and policies in the state. A large proportion of state residents (41%) are eligible for MCH services through the Maternal and Child Health Branch (MCHB) of the FHSD: 247,259 women are of childbearing age (15-44 years) - the key demographic referenced in this report (State of Hawai'i DOH, 2010).

MCHB is responsible for oversight, resource allocation, and tracking of Title X Family Planning federal funds. Through Title X, the Family Planning Program supports 41 clinics and community sites, serving 21,440 clients in FY 2012 (Frost et al., 2014). This program is an important lifeline, as it ensures access to affordable birth control and reproductive health services, particularly for low-income and hard-to-reach individuals (e.g., uninsured or underinsured, immigrants, persons with limited English proficiency, etc.).

## Wonderful Journey… A Woman's Life & Wellness Planning Journal

**Need**

According to a 2010 analysis of Pregnancy Risk Assessment Monitoring System (PRAMS) 2004-2008 data, 45% of pregnancies in the State of Hawai'i are unintended, i.e., they are either mistimed (32%) or unwanted (13%) (Schempf et al., 2010). "Other" Pacific Islander, Samoan, Black, Hawaiian, Filipino and Hispanic women, younger, less educated, unmarried, uninsured or Medicaid/QUEST insured, and Hawai'i County residents were more likely to have an unintended pregnancy (Schempf et al., 2010). Unintended pregnancy was also related to a number of adverse health behaviors, including late or no prenatal care, substance use, never breastfeeding, postpartum depression, and short birth intervals (Schempf et al., 2010). Births resulting from unintended pregnancies in Hawai'i cost the state and federal governments $44 million per year (Sonfield & Kost, 2013). In direct response to these trends, the MCHB placed reduced unintended pregnancy as a top priority in the 2010 MCH Title V Needs Assessment.

In 2006, the Centers for Disease Control and Prevention (CDC) recommended: "There should be individual responsibility across the lifespan. Each woman, man, and couple should be encouraged to have a reproductive life plan." (Johnson et al., 2006) As of January 2015 (baseline, pre-booklet implementation), 23% of women receiving services at Title X clinics in Hawai'i had completed a reproductive life plan (RLP) during their last family planning visit (D. Hayes, personal communication, January 8, 2015).

The RLP arose from a CDC preconception health workgroup as a method to increase the number of planned pregnancies and improve birth outcomes. The RLP is a tool for reproductive health promotion within a lifecycle perspective (Moos et al., 2008), which consists of a set of non-normative questions about having or not having children (Moos, 2003). The RLP aims to encourage both women and men to reflect on their reproductive intentions and to find strategies

for successful family planning (Johnson et al., 2006). The RLP can be used both in counseling and in a written form, as booklets or worksheets. Several descriptions of the RLP are available in the literature (Moos, 2003; Sanders, 2009; Malnory & Johnson, 2011; Barry, 2011). In theory, the continuous nature of a RLP provides a seamless approach to care that includes preconception, interconception, or prenatal care (Malnory & Johnson, 2011).

There is limited literature on the efficacy of RLPs in improving health outcomes. However, one study demonstrates that exposed clients appreciated the incorporation of the RLP in primary care settings (Dunlop et al., 2010). A randomized controlled trial conducted among Swedish university students found significant differences in knowledge of reproduction between experimental and control groups after an RLP intervention (Stern et al., 2013).

**Context**

Audrey Inaba, RN, a principal developer of the *Wonderful Journey* ("booklet"), learned of a journal developed by Philadelphia Healthy Start entitled *Your Life, Your Plan* that aimed to promote MCH through a home visiting program (HRSA, no date). Ms. Inaba requested a copy of the journal and received permission to revise the Philadelphia edition to meet the needs of women on the Island of Hawai'i (or "the Big Island"). In 2013, Haley Rosehill, MPH, conducted five focus groups with Native Hawaiian, Chuukese, Marshallese, Hispanic, and teen groups, in which she asked for feedback on the Philadelphia journal and developed the *Wonderful Journey* based on guidance from these key informants. Ms. Inaba and Ms. Rosehill designed the booklet to facilitate the Big Island's existing interconception health home visiting program, wherein a designated home visitor meets with the same woman over time and builds rapport, trust, and discusses the client's health and life goals over a series of meetings (A. Inaba, personal communication, January 5, 2015).

The recent termination of the Big Island Perinatal Health Disparities Project grant presented a limitation in the booklet's scale-up on the Big Island through the home visiting program. However, given that the DOH allocates significant state and federal funding to clinics and satellite centers, implementing the *Wonderful Journey* to a larger pool of women in other health care contexts than it was originally conceived is a strength of the program.

The MCHB determined that the *Wonderful Journey* offered an opportunity to (1) implement a program aligned with its health outcome priorities identified in the 2010 Title V MCH Needs Assessment; and (2) utilize an existing resource that was developed to meet the needs of diverse subpopulations living in the State of Hawai'i. The MCHB identified Title X family planning clinics as the appropriate venue for booklet distribution, as these sites reach vulnerable populations experiencing the highest rates of unintended pregnancy. Moreover, federal funding mandates a tracking database, which includes relevant information for evaluation reported on the Client Visit Record (CVR). The *Wonderful Journey* is also aligned with the recent CDC emphasis on reproductive life planning (Johnson et al., 2006).

**Target population**

The *Wonderful Journey* is targeted to women of reproductive age (15-44 years), who live in the State of Hawai'i, and receive family planning services in the 41 centers receiving Title X funding, including safety net institutions and satellite clinics. In 2012, Title X served 21,440 women in the state (Frost et al., 2014), 5,850 of whom were adolescents (Frost et al., 2013).

### Objectives

The *Wonderful Journey* program aims to: (1) in the short term, facilitate the target population's development of an RLP with guidance from a trained health professional, either a doctor, nurse, health educator, case manager, medical assistant, etc., depending on clinic staffing; (2) in the long-term, women's internalization of their RLP may facilitate their taking action to optimize their health before pregnancy; (3) by attaining optimal preconception health, this may increase the number of planned pregnancies and improve birth outcomes (Johnson et al., 2006), particularly among vulnerable groups reached in Title X clinics in the State of Hawai'i.

### Program Development

As discussed above, the *Wonderful Journey* was initially developed in 2013 to be implemented on the Island of Hawai'i within a home visiting model. The larger-scale distribution in Title X clinics by MCHB is in the initial planning stages. During our site visit (January 12-16, 2015), Title X personnel offered insights into acceptability, feasibility, and use of the booklet for both staff and populations served (**Appendix A: *Resources from Week 2 Stakeholder Meetings***). After meetings with key stakeholders and presenting our findings on January 16, the MCHB staff agreed that further booklet edits were necessary before program implementation and evaluation would begin. Once edits are completed, the FHSD hopes to conduct a formative evaluation to determine best practices in booklet distribution. Ultimately, this evaluation can ensure that the booklet facilitates client development of RLPs at Title X clinics throughout the State of Hawai'i.

## Stakeholder Analysis

We conducted a stakeholder analysis using an approach developed by the World Bank, which facilitates institutional and policy reform by *accounting for* and *incorporating* the needs of those who have an interest in the reforms under consideration (The World Bank Group, 2001). Our analysis includes six categories ("involvement in evaluation", "interest in evaluation", "influence/power", "resources", "position [promoter, defender, latent, apathetic]", "impact of evaluation on stakeholder"). We then classified stakeholders with respect to their *high*, *medium*, or *low* stake across each domain. We identified three groups of stakeholders in the evaluation: (1) State of Hawai'i Department of Health, particularly the FHSD (evaluators); (2) Title X clinic staff (implementers); and (3) Title X clients, namely women of reproductive age who live in Hawai'i (recipients). **Appendix B** is a stakeholder table, which offers a detailed summary of the main findings from our analysis. Below we discuss the overarching considerations for the formative evaluation of the booklet.

### Stakeholders: FHSD, Title X Clinic Staff and Clients

Importantly, the FHSD has a significant stake in each component of the evaluation. The FHSD is highly *interested* in undertaking the evaluation, acts as a very *influential* player in both conducting the evaluation and ensuring its quality, will allocate staff time and financial *resources*, *promote* the program, and ultimately use the *findings* of this evaluation to determine whether the program should be funded in the future. On the other hand, Title X clinic staff and clients have less time, involvement, and commitment to the evaluation. In order to maximize the success of the evaluation (and complete the evaluation activities to ascertain effect on short and long-term outcomes), it is essential to consider the differences in evaluation engagement levels between the FHSD, the implementers, and the recipients.

In ***Recommendations***, we offer methods to ensure cultural competency of the booklet – an important strategy to gain staff and client buy-in. Furthermore, by undertaking the activities we discuss in the **Logic Model** and ***Recommendations***: **Implementation Plan** (e.g., ongoing technical assistance, user testing, and training sessions), it may be possible to engage stakeholders, ensure uptake of the program, and strengthen linkages between the evaluators (the FHSD) and the implementers (Title X clinic staff).

# Evaluation

### Evaluation Objectives

The purpose of this evaluation is to understand how booklet activities are delivered, in order to maximize the potential for success and demonstrate intervention effectiveness. The model for assessing program delivery, and thereby formulating objectives, is based on the RE-AIM framework described below. In particular, the purpose of this process evaluation is to:

- Measure the degree to which intervention reached target participants.
- Measure the degree to which intervention facilitated creation of RLPs.
- Assess the degree to which intervention was adopted by implementers.
- Assess the degree to which intervention was implemented as planned.
- Assess the degree to which intervention can be maintained in practice.
- Engage key stakeholders in evaluation to optimize buy-in and potential for success.
- Provide data to inform adjustments to booklet implementation and outcome evaluation.

### Evaluation Questions

1. Do reproductive age women in Hawai'i at Title X clinics like, acquire, and use the booklet? What are the demographic characteristics of these women?
2. Does incorporating the *Wonderful Journey* into Title X clinic programming result in an increase in the creation of RLPs? In what ways does it help in supporting family planning in general?
3. Do booklet implementers agree to use the booklet in practice? How do they use it?
4. Does the booklet fit into routine organizational practice? What influences the booklet's ability to be sustained long-term?

### Conceptual Framework

This evaluation is rooted in two conceptual models, the CDC Framework for Program Evaluation and the RE-AIM Framework, which jointly inform research questions, study design, methods of data collection and analysis, and considerations for dissemination and use.

#### CDC Framework for Program Evaluation

The CDC Framework for Program Evaluation highlights that the product of this iterative and interdisciplinary process provides a "systematic way to improve and account for public health actions" (Koplan et al., 1999). This tool is practical, non-prescriptive and summarizes both the action steps and technical standards for optimal program evaluation. By adhering to the steps and standards of the framework, we can understand the program's context, as well as encourage evaluation strategies that integrate it into routine program operations. The approach also emphasizes participatory methods to evaluation, involving all stakeholders, rather than exclusively turning to evaluation experts.

The six action steps in the framework include: (1) engaging stakeholders, (2) describing the program, (3) focusing the evaluation design, (4) gathering credible evidence, (5) justifying conclusions, and (6) ensuring use and lessons learned. The Framework also articulates standards to assess the quality of evaluation activities, ensuring that it is (1) useful, (2) feasible, (3) ethical, and (4) accurate.

## RE-AIM Framework

The RE-AIM Framework is a tool to systematically and comprehensively evaluate multi-level health promotion interventions (Glasgow et al., 1999). RE-AIM includes five components that encapsulate public health impact: *reach*, *effectiveness*, *adoption*, *implementation*, and *maintenance*. RE-AIM has been employed in both academic and practice-based evaluations of over 200 health promotion and health education programs. The model is primarily utilized in planning stages to understand how the program is developing, and report preliminary results of health behavior change programs (Gaglio et al., 2013). Thus, we operationalize the five pillars of the framework as both our evaluation questions as well as our indicators of long-term outcomes reflecting a "useful booklet".

### Logic Model

Logic models offer a "picture of how [an] organization does its work" (Kellogg Foundation, 2004). The elements of our logic model are organized in the following categories: *inputs*, *activities* that lead to intended *short* and *long-term outcomes*, with *outputs* indicating that activities are taking place. A graphical depiction of the logic model can be found in **Appendix C**.

The *inputs* involved in this evaluation are our three main stakeholders: (1) the FHSD serving as the manager and evaluator of this project, with primary contributions by the Reproductive Health Services Unit (RHSU), CDC Assigned Epidemiologist, and CDC/CSTE Applied Epidemiology Fellow; (2) 41 clinics and satellite centers offering Title X services in the State of Hawai'i serving as the site for booklet implementation, and (3) the target population, i.e., reproductive age women in Hawai'i receiving Title X services.

The *activities* and their associated *outputs* constitute activities of the formative evaluation, including (1) pilot testing with the target population to more thoroughly understand optimal means to implement, with associated outputs, including notes, transcripts, and interpretation generated from this testing; (2) ongoing technical assistance provided to the Title X clinics and logged by the RHSU, which supports booklet implementation, captures information, and propels a feedback loop between evaluators and implementers; the corresponding outputs are the RHSU logs which capture this data; (3) tracking of booklet distribution maintained by the Title X staff; the output is the Booklet Implementer Log at each site; (4) user testing with booklet recipients to understand its effectiveness; the outputs are notes, transcripts, and interpretation generated from this testing; and finally (5) linking the Booklet Implementer Log to the CVR to connect booklet use to clinical outcomes, particularly client's adoption of a RLP; the outputs are analyses of this database.

The *short and long-term outcomes* include: (1) a booklet that reflects input from target population; (2) a booklet that reflects input from booklet implementers; (3) DOH understands and supports booklet implementation; (4) booklet implementers are supported in delivering and reporting the booklet; (5) DOH understands booklet reach; (6) DOH understands booklet effectiveness in helping women create RLPs; and (7) DOH understands booklet effectiveness in

helping women achieve other family planning and reproductive health outcomes. The ways in which activities logically connect to these outcomes, and theoretical links to long-term health outcomes are elucidated in the logic model's graphical presentation (**Appendix C**).

**Evaluation Study Design**

The purpose of this evaluation is to understand the process by which the booklet intervention is delivered and its impact in supporting reproductive age women in Hawai'i to create RLPs. The hypothesis is that accessing a tool that presents family planning in the context of local cultural norms, life goals, and life skills will increase Title X clinics' ability to facilitate their female clients' development of an RLP.

The evaluation will employ a quasi-experimental design by examining the impact of the intervention and measuring key indicators before and at intervals subsequent to booklet implementation. Random assignment to a treatment and control group is not feasible and inappropriate for this preliminary stage of the evaluation. Experimental designs are prohibitively expensive and labor intensive, and evaluators are seeking to explore relationships and processes, rather than establish causation. In practice, program evaluation generally operates outside of true experimental conditions (Sherman et al., 1997; Shadish et al., 2002).

**Table 1. Study Design**

| Timeline | | $T_1$ (Pre) | Booklet | $T_2$ (3 Months) | $T_3$ (6 Months) | $T_4$ (12 Months) | $T_N$ (Ongoing TA) |
|---|---|---|---|---|---|---|---|
| Intervention | NR | $O_1$ | X | $O_2$ | $O_3$ | $O_4$ | $O_N$ |
| Comparison | NR | $O_1$ | -- | $O_2$ | $O_3$ | $O_4$ | $O_N$ |

**NR**: Non-randomized (i.e. non-equivalent groups)
**O**: Observations (technical assistance check-ins, collection of booklet implementer logs) made that will occur before implementation, and at 3, 6, and 12 months.
**X**: Participation in booklet intervention, defined as receiving the booklet from clinic staff at Title X clinic.

The *intervention group* will be comprised of pre- and interconception women of reproductive age (15-44 years) living in Hawai'i, receiving family planning services from Title X clinics. The *comparison group* will consist of pre- and interconception women of reproductive age (15-44 years) living in Hawai'i, also receiving services from Title X clinics but who do not receive the booklet.

Without random assignment, we can reasonably assume that the groups are nonequivalent. In other words, while they may match on important demographic characteristics, there is likely to be some fundamental difference between these groups. It may be difficult to control for these differences (e.g., personality or cultural traits that would lead one person to take the booklet over another), which may influence the study outcome. However, the nonequivalent group design also offers some strengths in that it eliminates potential sources of bias that would otherwise be threatening, including history (internal or external events that may influence the outcome), testing (the effect that a pre-test itself might have on the outcome during later post-tests), and instrumentation (outcome changing due to the observation itself). Thus, while this study design is not the gold standard of a true experiment, it is a reasonable compromise that protects against many potential threats in accurately understanding the booklet's impact and process (i.e., internal validity).

## Methods

We recommend a mixed-methods convergence model for data collection, management, and analysis of this formative evaluation. This approach utilizes quantitative and qualitative methods to capture data concurrently (Creswell & Garrett, 2008). Both streams are prioritized equally, and are kept independent in terms of data collection but merged during analysis and interpretation. A mixed-methods approach offers a complete picture of the phenomenon of interest, as evaluators can examine the extent to which different strands of data validate, diverge from, or qualify each other (i.e., multi-method triangulation). This information is particularly important during formative evaluation.

### Data Collection Procedures

Qualitative data collection will involve the administration of focus groups and/or participant observations during pilot testing and user focus groups. Qualitative data can be captured through open-ended components of the RHSU Technical Assistance (TA) Log. Depending on staffing and financial resources allocated, the FHSD can decide between a "basic" and "comprehensive" package of evaluation activities. Basic activities include: (1) the RHSU Technical Assistance (TA) Log, (2) the Booklet Implementer Log, and (3) the Linked CVR-Booklet Implementer Log Database. The comprehensive activities include the aforementioned basic activities, as well as (4) pilot testing, and (5) user testing. Here we describe these activities in consecutive order of completion. In the **Logic Model** (**Appendix C**), we highlight these suggested comprehensive activities in orange, while basic activities are indicated in blue.

For *pilot testing*, we recommend employing both focus groups and semi-structured interviews. Focus groups allow the group to explore the booklet in a dynamic social setting, which may be important if this booklet is to be implemented within a group-based model. However, semi-structured interviews with women within the target population may be an alternative qualitative approach, given our stakeholder meeting findings regarding the incongruence of birth control and family planning among many subcultures in Hawai'i (see ***Recommendations*: Booklet Improvements**). Semi-structured interviews allow for an in-depth assessment of the booklet from an individual's perspective outside of a setting in which social norms may bear great influence on responses (Padgett, 1998; Ulin et al., 2005). The goal of either form of pilot testing will be to ascertain women's reactions to the booklet's content, as well as its proposed use within the Title X clinic setting. If feasible, financial incentives (e.g., gift cards, cash) should be offered to participants in recognition of their time and to optimize recruitment.

For *user testing,* we recommend using a qualitative method to match the form of implementation that has been selected (i.e., focus groups if the MCHB opts to implement the booklet in group visits, or brief semi-structured interviews if it is implemented during clinic visits). These tests will likely take different forms depending on the implementing clinic, so flexibility is essential. The goal of this stage of qualitative data collection will be to understand how useful the booklet is in helping women create and sustain an RLP (i.e., effectiveness), as well as to engage in other behaviors around family planning and contraception. Compensation is also recommended for participation in user testing.

Please see proposed qualitative data instruments and technical guidance notes on qualitative data collection and analysis (for either focus groups or semi-structured interviews), located within **Appendices D** and **E**, respectively.

Quantitative data collection will involve gathering data from the RHSU TA Log, the Booklet Implementer Log, and the linked CVR-Booklet Implementer Log Database (**Appendix F**). The RHSU TA Log will contain qualitative data on booklet implementer adoption and potential for maintenance, and quantitative data on implementation at the clinic level. The Booklet Implementer Log will contain counts on booklets distributed to women (i.e., reach). Finally, the linked Booklet Implementer Log-CVR database provides data on RLP creation specifically connected to unique client IDs to ascertain the extent to which booklet participation predicts RLP creation as well as other CVR-indicated outcomes (i.e., effectiveness).
Technical guidance notes on quantitative data collection/analysis are located in **Appendix E**.
Data collection activities (including the type of data and RE-AIM dimension they capture) are explicated in this table and in the **Logic Model** (**Appendix C**).

**Table 2. Intervention Components**

| Activity | Quantitative | Qualitative | RE-AIM Dimension captured |
|---|---|---|---|
| Pilot Testing | | X | N/A |
| DOH RHSU Ongoing Technical Assistance Log | X | X | Adoption Implementation Maintenance |
| Booklet Implementer Log | X | X | Reach Effectiveness |
| User Testing | | X | Effectiveness |
| Booklet Implementer Log-CVR Linked Database | X | | Effectiveness |

## Data Management

Qualitative and quantitative data will be managed by MCHB. All hard copies of notes and logs collected by staff will be kept at the MCHB office. Qualitative notes will be transcribed and stored electronically. Electronic copies of notes and logs will be stored on the MCHB hard drive. Each implementing clinic will be responsible for the management and maintenance of their own Booklet Implementer Logs throughout the evaluation duration with updated logs to be sent to the RHSU at designated intervals (i.e., 3, 6, and 12 months).

## Data Analysis and Interpretation

Qualitative data analysis can take various forms ranging from mild to highly rigorous approaches. Acknowledging the limited staff time available to engage in a deep qualitative analysis process–particularly for a formative evaluation–we recommend using a method comparable to a consensual qualitative research (CQR) approach. This method is broadly defined as a process where meetings are held to describe phenomena, few cases are deeply investigated, context is recognized and reported, and consensus-based decision-making is attained (Hill et al., 1997). Alternate modes of qualitative analysis for this evaluation are described in **Appendix E**.

Quantitative data analysis will largely involve tabulations of univariate statistics (descriptive data) and bivariate statistics (relationships between intervention and various outcomes including

RLP creation). As this is a formative evaluation, multivariate analyses need not be conducted, but can be considered, as many individual-level covariates are captured by the CVR.
The CDC Assigned Epidemiologist and/or CDC/CSTE Applied Epidemiology Fellow will undertake quantitative and qualitative analysis. These results will be conveyed to RHSU staff, so that they can share initial findings with Title X clinics during the 6 and 12-month RHSU TA visits. This feedback loop between evaluator and implementer will allow Title X staff to gauge whether evaluators understand their concerns, and interpretations align with on-the-ground experiences. Thus, TA serves as a meaningful mechanism for both providing support and engaging implementers.

**Sampling Approach**

Various sampling approaches should be considered, as this evaluation includes multiple forms of data collection. For *pilot tests*, we recommend a criterion-based purposeful sampling approach for maximum heterogeneity, or identifying women of reproductive age who receive care from clinics that receive Title X funding and are capable of becoming pregnant (i.e., are not currently pregnant, have not had a hysterectomy, etc.), and then hosting focus group discussions to understand client reactions to the booklet and how it might be used in the clinic setting. In recruiting these groups, flyers and other forms of publicity should seek to create focus groups that yield maximum diversity of participants (i.e., maximum variation sampling based on ethnicity or other characteristics of interest). For example, consider the scenario in which a reasonable variety of participants are observed in several focus groups, but a certain ethnic group is never recruited or seen at focus groups. In this circumstance, it may be prudent to purposefully target that ethnic group for inclusion so that their opinions are appropriately reflected in the evaluation (e.g., recruiting at a Chuukese-specific support groups). This is a particular concern given the sensitive nature and potentially varying cultural perspectives on the booklet's contents.

Although a number of preliminary focus groups and key informant meetings have been completed, these may not have been fully representative of the make-up of clinic staff or booklet recipients. Therefore, we recommend conducting user testing with more groups and greater attention to the representativeness of the target population.

For the *RHSU TA Log,* the sampling frame will include Title X Booklet implementing clinics. For the *Booklet Implementer Log* and *Linked CVR-Booklet Implementer Log Database,* the sampling frame will be comprised of reproductive age (15-44) women at Title X clinics who received the booklet. For the *user tests,* the sampling frame will consist of booklet users, depending on how the booklet is implemented.

## Resource Considerations and Assumptions

Potential resource constraints, underlying assumptions, and threats to validity should be considered. These factors could affect program implementation and evaluation, and thus achievement of program goals. We acknowledge that placing this booklet solely within the purview of Title X reimbursement may prove challenging, as in practice, health care centers offer a host of services from a variety of funding sources (e.g., state-funded Perinatal Support Services). Thus, we propose that all evaluation activities are framed within the Title X context but offer suggestions for other streams to consider during implementation (see ***Recommendations:*** **Booklet Improvement**).

There are several assumptions underlying this program, which, if not reconciled and/or reported, can lead to misinterpretations of results. They include:

- Pilot test participants embody the views/values of the target population as a whole.
- RHSU has the staff time and capacity to conduct TA visits.
- Clients receiving a booklet have a client ID in the CVR.
- Clinic staff has the time and are willing to complete the Booklet Implementer Log.
- An effective booklet will result in an increase in RLPs made among women in Hawai'i.
- An important reason that unplanned pregnancy high in Hawai'i is because women do not currently and/or face difficulties in appropriate family planning and birth spacing.
- A formative evaluation is an important (and necessary) precedent to evaluating outcomes.

## Potential Threats to Validity

Foreseeable challenges in our ability to ascertain the extent to which the data gathered are meaningful (i.e., internal validity) based on non-equivalent group study design include:

*Additive effects with selection* refers to one group potentially responding differentially to other sources of bias (e.g., have different experiences, mature at different rates, may differentially regress to the mean, etc.), which may manifest as group differences at the end of the evaluation linked to these threats, rather than the intervention itself.

*Observer bias* occurs when the evaluator's cognitive biases make them subconsciously influence the participants of the study – in this case, it might take the form of DOH staff giving more or preferential support to clinics with whom they might have a personal relationship.

*Contamination* occurs when members of the comparison group begin to receive the intervention, either inadvertently or purposefully. There is potential for contamination with this intervention particularly because we heard that, in practice, community health centers see entire families and communities of people – certain women may be sharing the booklet and/or information gleaned from the booklet with her family and friends, who may also be part of the target population.

The *Hawthorne effect* may occur when a participant might perform or act differently in reaction to her awareness of being observed. There is a potential for the Hawthorne effect for both the booklet implementer (e.g., booklet implementer might report that implementation is operating positively to the RHSU staff, who are partial funders of these clinics) and the booklet user (e.g., clients might report differentially when being observed in the user testing stage, acknowledging that DOH evaluators are government officials). Ostensibly, the threat of Hawthorne effects in this evaluation is based on the perceived power dynamics that might influence responses at multiple levels.

While these threats merit consideration, we reaffirm our recommendation against a comprehensive experimental design for this formative evaluation, as described in ***Evaluation:*** **Evaluation Study Design**. However, acknowledgment of these threats will be important in any summative discussions or written reports of this evaluation.

# Recommendations

**Booklet Improvement: Ensuring cultural competency and feasibility**

During key stakeholder meetings at five Title X clinics on Oahu, we received important feedback from clinic staff about the cultural relevance of the booklet and its core messages. These insights should be incorporated wherever possible, in order to improve the booklet. Discussions included an array of professional perspectives with varying levels of training and involvement in the communities served, e.g., health educators, case managers, translators, a nurse-midwife, clinic managers, and Director of Preventive Services.

First, staff doubted the resonance of the "unintended pregnancy" paradigm, particularly among marginalized populations living in Hawai'i, e.g., Micronesian and Native Hawaiian women. Staff reported that women in many cultures served at the clinics are expected to have children, and that children are considered a blessing regardless of the circumstances of conception (e.g., intended or not), and thus, pregnancy is not viewed as a barrier to women's ability to achieve their goals. These anecdotal reports are also supported by qualitative research conducted with Native Hawaiian women (Soon et al., 2014). Therefore, our meetings exposed concerns in the underlying assumptions and values incorporated into the *Wonderful Journey*.

Second, there was unease regarding the medium of the booklet. The majority of clinic staff stated that their clients were raised in oral cultures, such that "talking story" is the method by which women self-reflect and interpret their lives. Further, women with limited literacy, English language skills, and educational attainment may be resistant to the booklet because it is "like school" and certain sections require complex writing and analysis. In order to ensure cultural competence and client buy-in, reconsideration of the booklet in its current form is essential and could be further explored through pilot testing. We recommend approaches that might highlight women's commitment to being mothers in their own language through conversation, rather than writing.

Clinic staff also raised inconsistency of messaging and formatting within the booklet (e.g., "my favorite color is…" (p. 4) v. "where does my money really go…" budgeting worksheet (p. 22)). We suggest that the MCHB meets and discusses the booklet and makes edits for clarity and formatting, in order to craft a more cohesive, consistent, and relevant product. Finally, given reservations about the booklet's length, it would be paramount to offer a visually engaging, simple one-page overview of the booklet's overarching topics. The one-pager could be offered to all clients as a point of engagement, as well as serve as a guide upon which booklet implementers could build discussion points, activities and games, or other strategies for client engagement.

Given the space and time constraints in the Title X clinical setting, it may be useful to consider alternate approaches to booklet delivery. Suggestions from stakeholders included administration in existing support groups and classes held by case managers and health educators. Outside of Title X family planning services, clinic staff suggested implementing the booklet where there are "captive audiences" who could work through the booklet over time with the same women, e.g., school/after school programs, home visiting, detention centers, and residential treatment facilities, where outreach and group programming already occurs.
Alternatively, given reporting that health centers in Hawai'i offer a variety of services using multiple funding streams, it may be prudent to consider linking booklet implementation in Title X services to other client services, e.g., state-funded Perinatal Support Services. In reality, we

heard from clinic staff that many women develop an RLP during the final trimester of their pregnancy – when they would not be eligible to receive Title X family planning services and would be missed in the evaluation outlined above. Given that clients have the same unique ID number on the Title X CVR and the Perinatal Support Services Data Collection Form, this may be feasible and more aligned with clinic realities.

**Implementation Plan**

After the MCHB ascertains feasibility and staffing for editing, as well as the appropriate route of booklet administration, it should take action to improve the booklet and submit the program for DOH clearance. Next, the RHSU should utilize a session of the regular video conference call with Title X staff statewide as a booklet launch event. This session may garner buy-in from call participants, who may or may not be the implementers of the booklet depending on the clinic context. Next, the MCHB should develop training materials and conduct an in-person "train-the-trainer" session with representatives from each Title X clinic – ideally a supervisor of the clinic-identified booklet implementer (e.g., health educator, case manager, etc.). The training session can include mock booklet demonstration, an introduction to reproductive life plans, and guidance around documentation and logging processes. These in-person meetings can ensure that those providing the booklet are aware of its purpose, understand its utility, and incorporate it into existing practice. Copies of the *Wonderful Journey* should then be printed and distributed to the clinics. During program rollout, the RHSU should offer ongoing technical assistance and guidance to ensure that any barriers are identified and overcome expeditiously.

**Evaluation Plan**

The stakeholder meetings in the Title X clinics provided vital information that underpins our thought processes and suggestions for this evaluation report. We learned that evaluation for similar family planning and health education booklets and brochures was fairly minimal, e.g., optional sign-in sheets or informal assessment approaches to help the facilitator survey the group (e.g. oral pre/post knowledge-based questions). In addition, we learned that assessment attempts using paper-based or overly structured mechanisms tended to yield low response rates and/or could alienate clients, particularly younger groups. Thus, the evaluation design, data collection methods, and sampling approach steers away from onerous paper-based client surveys, instead placing evaluation activities upon the MCHB and, to a lesser degree, booklet implementers. Where data is gathered from clients directly, it is done so in a qualitative setting that integrates with existing programming.

See ***Evaluation*** for our recommendations on how to conceive of and implement this formative evaluation over the course of the year.

## Dissemination and Use

The results and interpretation of this evaluation will be made available between DOH and Title X implementing clinics throughout the year of evaluation as a means to monitor program development and implementation. After the 12-month TA visit, DOH should write a summary report outlining the evaluation activities, results, and interpretation for the year, key takeaways to drive booklet reconfiguration and improvement, and best practices among clinics in booklet provision. This report will be shared with all clinics serving women in Hawai'i, and be made publicly available on the DOH website.

Qualitative and quantitative findings over the course of the year regarding reach, effectiveness, adoption, implementation, and maintenance will be used as a basis for discussions on how to improve booklet content and implementation procedures for the following year. These discussions should be facilitated by DOH, but also include the input of Title X clinics and women in the target population – with the ultimate goal of making both booklet implementation and its outcome evaluation framework concrete (see **Appendix G** for preliminary considerations for the outcome evaluation). In addition, best practices that are gleaned should be shared with all clinics in Hawai'i to boost their ability to deliver the booklet efficaciously. Finally, the results of this process can be shared within state and nationwide meetings/conferences – particularly those concerning MCH and family planning programs – to offer a foundation upon which other agencies might consider designing and evaluating similar tools.

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# Appendices

### *A. Resources from Week 2 Stakeholder Meetings*

The following resources (A1: Question Guides, A2: Feedback Form, A3: Key Takeways from Meetings, A4: Presentation Slide Deck) are documents that were developed during our Hawai'i site visit (January 12-16, 2015). They are included below to provide insight into the process and for your reference, if needed.

#### 1. Question Guides

Meeting #1: Orientation with Audrey Inaba and Maternal Child Health Branch, Monday 1/12/15

Thank you for letting us know about the health department, the community you serve and how things go around here (*add in anything else based off what you are initially presented with).*

[Marvin and Gabrielle introduce themselves]

As Don mentioned, both of us are here to learn about how to evaluate health programs but also to hopefully be of use to your Health Department in understanding how to both implement and assess the effectiveness of the "Wonderful Journey…" booklet. So, we'd love to hear more from Audrey and you all about this booklet.

1. To start, can you tell us about what spurred this booklet? Was it anecdotal based off your clinical experience, or maybe the CDC recommendation re: RLPs, or something else?
   PROBE/FOLLOW-UP: Who was part of the process in developing it?
   PROBE/FOLLOW-UP: To what extent have you shown it to women, and what has been the overall response so far?
   PROBE/FOLLOW-UP: What was your **original** conception of what this booklet should accomplish? Is it unplanned pregnancy? increasing self efficacy and women's agency?
2. Who is the target audience?
3. Which provider do you think would be best to discuss the "reproductive life plan" and walk through the Wonderful Journey with women? (e.g., women's health provider, nurse, community health worker, health educator, medical assistant)
4. We have heard from the team that unplanned pregnancy is an issue in Hawaii. What do you think might make it difficult for women to be engaged during the interconception period and how does this booklet fill this gap?
   PROBE/FOLLOW-UP: Emphasize different existing services at these clinics?

Meeting #2: Meeting with Bliss Kaneshiro, MD, MPH & Jennifer Elia, MPH, Monday 1/12/15

*Reproductive life plans*

1. Walk us through how you discuss reproductive life plans with our patients.
   PROBE/FOLLOW-UP: If "Nurse/another provider" – do you have a sense of how long that conversation usually lasts and what it looks like?
2. What is your take on reproductive life plans and their utility for your patients?

*Booklet*

1. This booklet is intended to facilitate a conversation with patients about reproductive life plans, in addition to placing reproductive life in the context of their everyday lives. What's your take on this booklet?
   PROBE/FOLLOW-UP: What comes to mind as you look through the booklet?
2. How might use of this booklet compare to current approaches to discussing reproductive life plans with patients?
3. How can the booklet be improved? Is there anything you wish you saw in here that you don't?

*Women's reproductive health and unintended pregnancy*

1. Given your work with women in Hawai'i, what do you think prevents some women from having optimal preconception health?
   PROBE/FOLLOW-UP: unintended pregnancy, birth spacing, contraceptive options and awareness, physical and emotional wellbeing
   PROBE: self-esteem, self-efficacy, locus of control

Meetings #3-7: Meeting with Federally Qualified Health Centers (KPHC, KKV, WCCHC, YO, PATH) Question Guide, 1/12/15-1/15/15

*Clinic*

1. Walk us through a woman's typical comprehensive primary care visit.
   PROBE: Generally, if you were a patient the first thing you walk in the door, what happens and then what follows?
2. Given the time and space constraints at the clinic, where do you think there could be opportunity and staffing to administer this booklet?
   PROBE/FOLLOW-UP: When do you currently engage patients with health education/health promotion materials/information?
3. What can kind of forms/administrative databases do [PROVIDERS IDENTIFIED ABOVE] currently complete?
   BASED ON RESPONSE, what do you think would be feasible for [PROVIDERS IDENTIFIED ABOVE] to track data regarding the booklet?
   PROBE/FOLLOW-UP: What about a log book, something similar?

*Reproductive life plan*

1. We've heard that there was a recent training in "reproductive life plans" and that it's been added to the Clinic Visit Record (CVR). Could you tell us about the training?
2. So far, how have patient and provider responded to reproductive life plans?
3. How long does this conversation typically take?

*Booklet*

1. What comes to mind as you go through the booklet?
2. Is the booklet culturally relevant for the communities served at this clinic?
   PROBE: If not, why?
3. How might use of this booklet compare to current conversations about reproductive life plans?
4. What might be the best approach for getting patient feedback?
   PROBE: Interviews in the waiting room? Discussion with existing support groups?
5. Do you have existing support groups or group visits that happen here, where focus groups might be able to take place?
6. How can the booklet be improved?

7. Is there anything in here that you think could be included to support the reproductive life plan?

*Women's reproductive health and unintended pregnancy*

1. We've talked about the booklet, and as you know, it's aimed at reproductive health. Given your work with women in Hawai'i, what do you think prevents some women from having optimal preconception health?
   PROBE: unintended pregnancy, birth spacing, contraception options and awareness, physical and emotional wellbeing
   PROBE: self-efficacy, self-esteem, locus of control

### 2. Feedback Form

Note: the form below was used to address power dynamics in stakeholder meetings, e.g., clinic staff's supervisors were often present and they were providing feedback to major funder of existing health program.

**Wonderful Journey Feedback Form**

Thanks for taking the time to talk with us today! We appreciate your feedback. Please provide additional comments below.

Is the booklet culturally appropriate for the communities served at this clinic?

Please select who you think would be best to start the “Wonderful Journey” booklet with women at the clinic? Check one and tell us why.

__ Doctors
__ Nurses, e.g., RNs, NPs
__ Midwives
__ Social workers
__ Health educators
__ Community health workers
__ Medical assistants
__ Clinic staff and administrators (e.g., front desk)

Why?

What would you change about the booklet? (e.g., cultural relevance, literacy levels, language, length, pictures, quotes)

## 3. Key Takeaways from Stakeholder Meetings

**Key takeaways for Day 1, Meetings 1-3**

**Maternal and Child Health Branch Staff**
**Researchers from University of Hawai'i, John A. Burns School of Medicine**
**Kalihi-Palama Health Center**

1. Tool for provider of reproductive life plan booklet to verify that they're hitting all the necessary points, without being overly prescriptive would be useful.
2. Importance of understanding diversity of Hawaiian subpopulations and there's some resistance to lumping a bunch of cultures into one document.
3. In many cultures, pregnancy and children is seen as a blessing and unintended pregnancy is not thought of as a problem and have support network to make it work.
4. Reproductive life plan in practice looks like the provider asking if the client wants to have a child in the next year. In the clinic setting this may only happen in the last weeks of pregnancy and initial postpartum period
5. Length of booklet is problematic and should be scaled down or thought should be given to how to make it into topic-based modules.
6. Stakeholders like the content areas, but don't think it's feasible to do either at one sitting, or expect to complete over multiple sessions with clients who have high loss to follow up.
7. Implementing the booklet might best be accomplished through a group model: allows for more time; groups lend themselves to relationship building, sharing, exchange between people. Groups are aligned with collectivist culture and ability to discuss issues with those who share same values.
8. Choice of topic is completely dictated by individual client needs and choices.
9. There hasn't been a lot of systematic evaluation or documentation of similar programs.
10. Role of interpreter is so important, as they are connected to the community or members themselves. Tapping into existing social networks is important – fundamental to the functioning of the health center and ensuring the mission of facilitating optimal health of clients.

**Key takeaways from Day 2, Meeting 4**

**Kohua Kalihi Valley (Health Center and Nature Preserve)**

1. Details like flowers, quotations, pictures and their placement really matter and may determine cultural relevance.
2. Clients have limited literacy and the booklet may be too complex and long.
3. Inconsistencies in booklet's messaging should be altered: some parts are too complex (e.g., budgeting) and others are almost patronizing (e.g., favorite color).
4. Child is considered a gift in spiritual and religious cultures. Idea behind reproductive life planning doesn't resonate with cultures where planning and spacing aren't "normal" and may be perceived negatively.
5. Majority of cultures served are oral and don't write, which is at odds with the journal's emphasis.
6. Women are already given similar tools and often don't return with them (e.g., Prenatal Passport in Centering group prenatal care).
7. Overall content is useful and important, but will likely not be useful over multiple sessions as designed. One-page summaries or modules, which could be integrated into

activities and discussions that they're already having around that topic, would be more practical.
8. Not a lot of evaluation currently taking place, particularly ones with paperwork attached to it. Client surveys won't be successful, instead think of creative evaluation methods ("vote with your feet"), which are more likely to achieve an honest answer.
9. Reproductive life plans are more in depth when they are provided by an OB case manager rather than a clinician. Clients don't even know how many kids they're going to have - pregnancy is something that "happens."

**Key takeaways from Day 3, Meeting 5**

**Waianae Coast Comprehensive Health Center**

1. Booklet is not appropriate for the clinical setting, would be best for a group, class, or a captive audience (e.g., detention center, school/after school program, inpatient treatment center).
2. Booklet is too long, overwhelming and intimidating.
3. Formatting, font, pictures, and tables are problematic, inconsistent and need revision.
4. More detailed conversations about reproductive life planning are happening now that it's required by grants and they developed a brochure to guide that discussion.
5. Women don't respond well to the idea of the "reproductive life plan." Core components of the reproductive life plan have to be framed for women to understand and relate to the concept.
6. Booklet distribution log could be feasible, particularly if it is linked into their electronic databases. Might be difficult because it's an internal system and may not be easily accessed by the Department of Health.
7. WCCHC engages in some evaluation of existing programs.
8. Clients engage with health promotion through stories. Booklet doesn't allow women to "talk stories."
9. Financial management and pregnancy don't go hand-in-hand. Doesn't resonate culturally because women's role is to have children, and are resilient and have support to make ends meet.
10. Short version would be helpful to introduce and then follow-up and show extended as needed or requested by client.
11. Evaluation doesn't fit in with other health education promotional material, is not the priority, clinics are trying to get by and don't have the capacity.

**Key takeaways from Day 4, Meetings 6 & 7**

**Waikiki Health Youth Outreach**
**PATH Clinic, Waikiki Health**

1. Wonderful Journey booklet was originally intended for a home visiting nurse to support optimal birth spacing and interconception health. Developers believed that it could be used as a personal journal or could be used to launch conversation or a facilitator guide.
2. Booklet feels too school-like, didactic, like a curriculum and would be alienating for people with low literacy and not "school people".
3. Clinician doesn't have time to do it, in clinical setting. Group setting may be preferable, especially where they meet over weeks and can cover different sections of the booklet.
4. Games and activities are more appropriate – clients don't respond to worksheets. Could be used as a basis for games and activities.

5. Reproductive life plan is met with mixed success or some are taken aback by this idea.
6. Overall clinic staff felt positively about the content covered in the booklet, liked the empowerment model, and understand its utility.
7. Success of the booklet depends on ability to get buy-in and show that it's useful, worth the limited "person time" available at clinics.
8. Existing evaluations are informal: keep a roster but "usefulness" is gauged by review at the beginning and end of a session – not documented, more anecdotal. Completion is not measured, but rather starting conversation and imparting information, might start the dialogue.
9. Extent of use of journal depends totally on the woman and whether that's the way they think and process their lives.
10. Lack of continuity of care would make it difficult for repeated conversations to happen, a captive audience would likely be more effective.
11. Don't want clients to feel that there is too much structure and evaluation because this might hamper perception that the clinic is a safe space.

## 4. Presentation Slide Deck

1/22/15

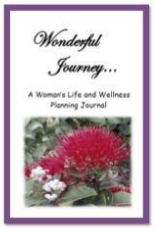
Wonderful Journey…
A Woman's Life and Wellness Planning Journal

Gabrielle Schechter and Marvin So
Harvard School of Public Health/CDC Program Evaluation Practicum
Hawai'i State Department of Health, Family Health Services Division

January 16, 2015

### Presentation Overview

- Practicum Timeline
- Key Findings from Stakeholder Meetings
- Recommendations for Improvement, Implementation and Evaluation
- Proposed Deliverables




### Week 1 Atlanta, GA

- Hawai'i Family Health Services Division participants:
  - Lois Arakaki, Public Health Educator, Reproductive Health Services Unit
  - Don Hayes, MCH Epidemiologist-CDC Assignee
  - Jaimie Hernandez, PREP Project Coordinator
  - Matt Turnure, CDC/CSTE Applied Epidemiology Fellow
- CDC training
- Team meetings
- Capacity building for students and Hawai'i Department of Health staff

### Week 2 Honolulu, HI

- Key Informant Meetings:
  - Maternal and Child Health Branch staff
  - Researchers at University of Hawaii, John A. Burns School of Medicine
  - Audrey Inaba & Haley Rosehill, developers of *Wonderful Journey*
  - Clinic staff
    - Kalihi-Palama Health Center
      - Interpreters, medical assistant, and outreach coordinator
    - Kokua Kalihi Valley
      - Case managers, health educators, WIC staff, nurse-midwife
    - Waianae Coast Comprehensive Health Center
      - Case managers and health educator
    - Waikiki Health Youth Outreach
      - Program manager and outreach coordinator
    - PATH Clinic, Waikiki Health
      - PATH Director and Waikiki Health Preventive Services Director, behavioral health coordinator, medical assistant

### Week 3 Boston, MA

- Back to 10 degree weather in Boston!
  - Incorporate feedback from Week 2 presentation
  - Meet, revise, and write
  - Submit to Program Evaluation Practicum Instructors for final commentary and revisions
  - Send final evaluation paper to Hawai'i Family Health Services Division Team (3-4 weeks)

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### Key Takeaways from Stakeholder Meetings

- Importance of cultural values and norms
- Booklet strengths
- Areas for booklet improvement
- Considerations for booklet implementation
- Considerations for booklet evaluation
- Limitations

1

## Key Takeaways from Stakeholder Meetings
### Importance of Cultural Values & Norms

- Resonance of "unintended pregnancy" and family planning among marginalized Hawai'i subpopulations?
- Women are expected to have children.
- Children are a blessing.
- Pregnancy is not a barrier to achieving life goals.
  - Family planning and financial management may not be a primary concern.
- Collectivist, family-centric, supportive cultures.
- Oral culture: may have limited literacy, education, and English language skills.

## Key Takeaways from Stakeholder Meetings
### Booklet strengths

- Empowering, client-centered approach.
- Valuable content.
- Incorporates in a single document messages about life skills and family planning.
- Thoughtfully adapted to Hawaiian context and subgroups.

## Key Takeaways from Stakeholder Meetings
### Areas for booklet improvement

- "Talk story" for client engagement on health topics. Applicability of journal format?
- The booklet is too long: potentially overwhelming and intimidating for many clients.
- The booklet is too didactic and "like school," may alienate clients.
- Inconsistencies in formatting, language choice, and content.
- Translation (e.g., Chuukese, Marshallese, Tagalog, Spanish, Hawaiian).

## Key Takeaways from Stakeholder Meetings
### Considerations for implementation

- Effective in a group, class, or captive audience (incarcerated, residential treatment facility, etc.).
  - Discuss one topic area during each group meeting.
  - Basis for teaching modules, discussion questions, or games/ activities.
- Appropriate facilitators are health educators, case managers, etc., not providers (e.g., MDs, NPs, PAs).
  - Stronger rapport and more time with clients.
  - May be the personnel who discuss clients' reproductive life plans.

## Key Takeaways from Stakeholder Meetings
### Considerations for evaluation

- Formal or structured evaluation may alienate clients – simple evaluation is best.
  - Consider creative approaches.
  - Take evaluation responsibility away from clients (i.e., no surveys).
- Similar reproductive life plan tools (e.g., journals, brochures) may be considered "useful" but are often not returned, and have not been linked to family planning outcomes.
- In practice, minimal and/or informal evaluation only.
- Basic log to track booklet distribution is feasible.
  - Data collection and abstraction challenges with varying clinic-based monitoring systems.

## Key Takeaways from Stakeholder Meetings
### Limitations

- Only met with 5 clinics on Oahu.
  - May not fully reflect diversity of women's health care services and needs in Hawai'i.
  - Primarily met with support staff (e.g., case management and health education), not health care providers or clinic management.
  - No meetings with home visiting personnel, the original context for booklet distribution.
  - Focus of discussion: Title X services, not Perinatal Support Services, which are also a point of care for reproductive life planning.
- Potential misreporting of honest beliefs about booklet.
  - Staff were often in the presence of their supervisor.
  - Visits by major funder (i.e., the State Department of Health) may compel clinic staff to appease interviewers.

## Recommendations

- Book improvement
- Implementation plan
- Evaluation plan

## Recommendations
### Booklet Improvement

- Make edits for consistency, clarity, and length.
- Create facilitator's guide which briefly covers each concept from the Booklet (e.g., one-page summary).
- Gather further insights regarding quote translation and images from cultural leaders.
- Reframe implementation approach:
  - Group administration by case managers, health educators, etc.
  - Alternate routes: schools/after school programs, home visiting, residential treatment facilities, detention centers.

## Recommendations
### Implementation Plan

MCHB convenes and selects actions for improvement, submits final Booklet for clearance

Video Conference Call to introduce Booklet and garner buy-in

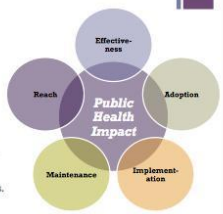
Develop and implement "train-the-trainer" session with case manager/health educator representative from each Title X clinic

Print and distribute Booklet to training participants

Ongoing technical assistance and guidance from DOH RHSU

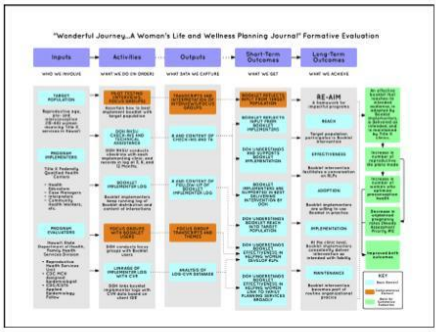
## Recommendations
### Evaluation Plan

- Formative evaluation
- RE-AIM (Glasgow 1999)
  - Framework to understand the impact of health promotion programs – particularly one -on-one counseling interventions and group sessions.
  - Intended to inform program planning of community-based interventions.
  - Applied in evaluations of over 200 health promotion programs.




## Recommendations
### Evaluation Plan

- Evaluation Questions
  - **Reach:** To what extent does the Booklet engage its target audience (reproductive age women living in Hawai'i receiving Title X services)?
  - **Effectiveness:** To what extent does the Booklet intervention achieve its intended outcome (facilitate a reproductive life plan conversation)?
  - **Adoption:** To what extent are Booklet implementers willing to deliver the Booklet intervention?
  - **Implementation:** To what extent is the Booklet intervention implemented according to plan at the organizational level?
  - **Maintenance:** To what extent does the Booklet have potential to be maintained as part of routine organizational practice?



## Recommendations
### Evaluation Plan

- Mixed-Methods Convergent Parallel Approach
  - Largely qualitative methods
  - Basic quantitative data collection
  - Non-equivalent group design
- Data Sources
  - Pilot Test Transcripts*
  - DOH RHSU Technical Assistance Log
  - Booklet Implementer Log
  - Focus Group Transcripts*
  - Linked CVR-Implementer Log Database

* For Comprehensive Formative Evaluation

| | Time 1 | Time 2 |
|---|---|---|
| Group A | BOOKLET | Group A |
| Group B | | Group B |

## Recommendations
### Outcome Evaluation

- Focus should first be on formative evaluation to improve the implementation of the Booklet, and thereby its chance of successfully achieving desired outcomes.
- Evaluate implementation beyond Title X services.
  - Link to Perinatal Support Services Data Collection Form, CVR, and alternate data sources, where feasible.
- Conduct chart audit.
- Long-term health outcomes:
  - Key preconception health performance indicators (e.g., behavioral and LARC uptake)
  - Decrease in unintended pregnancies
  - Improvement birth outcomes

## Proposed Deliverables

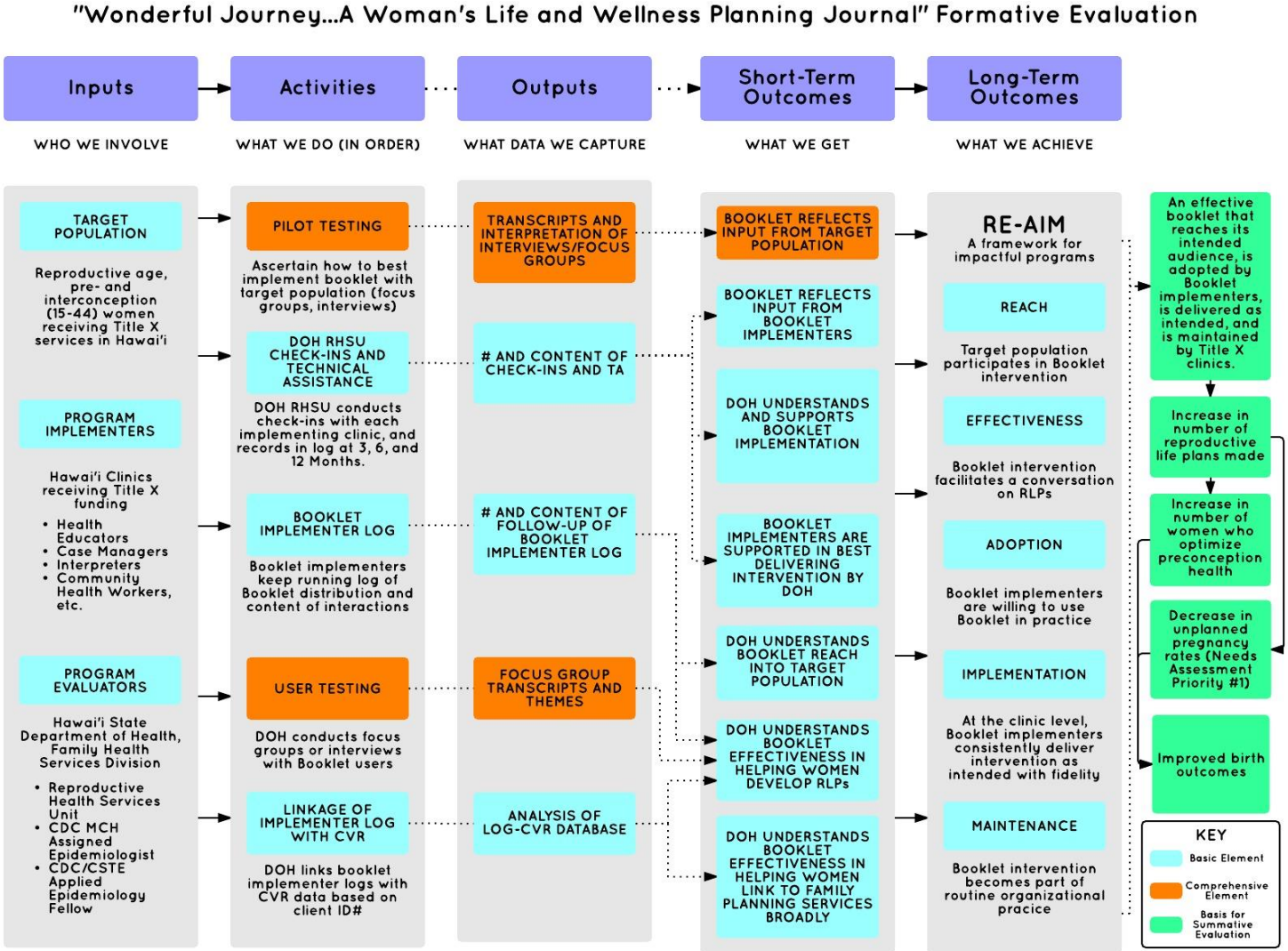
- Program Evaluation Final Report
- Program Evaluation Logic Model
- Notes from Stakeholder Meetings
- Technical Guidance Notes on Data Collection and Analysis
- Data Collection Instruments / Data Shells

## Mahalo!

## *B. Stakeholder Analysis*

| Stakeholder | Involvement in Evaluation | Interest in Evaluation | Influence / Power | Resources | Position (Promoter, Defender, Latent, Apathetic) | Impact of evaluation on stakeholder |
|---|---|---|---|---|---|---|
| **Hawai'i Department of Health, Family Health Services Division** | High: Directly involved in data collection (Pilot Testing, TA Log, Focus Groups), and data management and analysis. FHSD has expressed commitment to evaluation. | High: Wants to ensure booklet is as targeted and effective as possible - evaluation will provide information to optimize implementation, and ultimately achieve preconception health goal (see State of Hawai'i Title V Maternal and Child Health Needs Assessment). | High: Authorizes and executes evaluation. Responsible for selection and implementation of evaluation recommendations. | High: Funds implementation and evaluation. DOH staff time necessary, in order to carry out evaluation. | Promoter: Vested interested in booklet implementation success. Actions and decisions regarding evaluation can affect the booklet's success in practice. | High: Results of evaluation may affect program design and implementation, as well as focus of upcoming Title V Needs Assessment goals. May also serve as basis for future monitoring and evaluation efforts in clinics. |
| **Title X clinic staff** | Medium: Involved in some aspects of data collection (Booklet Implementer Log, Technical Assistance visits). | Low: Unfamiliar with process evaluation (have not completed for similar tools/booklets). However, evaluation may ultimately impact practice (e.g.. relationship with DOH funder). | Medium: Willingness to participate in evaluation will directly impact the evaluation and program's ability to achieve intended outcome. | Medium: Staff time is necessary to collect data. Key informants in local culture and feasibility of booklet in practice. | Latent: Attach a low priority to implementation and evaluation, but their actions can affect the booklet. | Medium: Evaluation results could influence DOH recommendations around reproductive life plans, as well as requirements around documentation and evaluation. |
| **Target population (women age 15-44 in Hawai'i receiving Title X services)** | Medium: Participate in some aspects of data collection (Pilot Testing and Focus Groups). | Low: Interest in evaluation from target population has not been ascertained. Surveys and traditional evaluation mechanisms have not been well received with previous DOH programs (e.g., low response rate). | Medium: Willingness to participate in evaluation will directly impact the evaluation and program's ability to achieve intended outcome. | Low: Lack the ability/time to engage in implementation and evaluation. Serve as a valuable source of data regarding cultural competence and feasibility. | Latent: Attach a low priority to implementation and evaluation, but their actions can affect booklet. | Medium: Evaluation results may influence care received at Title X clinics, including the provision and evaluation of similar family planning and health promotion tools. |

### *C. Logic Model*



### *D. Program Evaluation Data Collection Instruments*

#### 1. Pilot Testing Question Guide (FOCUS GROUP)

INTRODUCTION
Hello everyone, thank you for taking the time to come talk to us today about this booklet, which is called *Wonderful Journey.*

[Introduce self]

You have been asked to participate in this focus group because you are all experts. We'd love to hear what women like you think when you're going through the booklet, because we want to try to use it here at [Health center name] as a tool for reflection for women. Please be honest with sharing your thoughts because we will take what you say today to help make the booklet better.

Today, we would like to walk through this booklet together, section by section, and see how you feel. Each section is about some aspect of women's lives. We'll take five minutes of silence for you to simply go through the section, read, and fill out what's interesting to you. There's no right or wrong way to do it. Then, we'll chat for about five minutes after about what you liked, what stuck out to you, and what parts you filled out.

Does anyone have any questions before we begin?

Okay. Let's go ahead and start with the first section, "Knowing Myself...My Strengths, Weaknesses, and Skills".

QUESTIONS (to be used for all six sections)

1. How did you feel about this section as a whole?
2. What stood out to you about this section?
   PROBE: Was there anything you didn't like, or that bothered you?
   PROBE: Was there anything that you liked or found interesting?
3. How might you use what was covered in this section in your life?
4. Tell us about the parts of this section that you filled out.
   PROBE: Think about why you filled it out. Was it fun? Interesting? Something you genuinely wanted to think about for yourself? Etc.
5. Tell us about the parts of this section that you didn't fill out, or just skipped altogether.
   PROBE: Think about why you skipped it. Was it too long? Confusing? Boring? Something you didn't care about? Etc.

SECTIONS
*Knowing Myself...My Strengths, Weaknesses, and Skills*
*Taking Care of Myself*
*Supporting Myself*
*Being Myself...My Values, My Beliefs*
*Loving Myself...My Essence, My Relationships*
*My Life, My Plan...Family Planning and Reproductive Life Planning*

CLOSING QUESTION (after all six sections have been discussed)

1. Now that we've gone through the whole booklet, does anyone have final or overall thoughts? Anything that you haven't had a chance to share yet?
2. Would you recommend this booklet to a friend or family member? Why, or why not?

Thank you for spending your time with us today. As a thank you for your thoughts, each of you will receive a [compensation]. We appreciate it!

### 2. Pilot Testing Question Guide (SEMI-STRUCTURED INTERVIEW)

INTRODUCTION
Hello, thank you for taking the time to come talk to me today. We'll be taking a look at this booklet, which is called *Wonderful Journey.*

[Introduce self]

You have been asked to participate in this interview because I'd love to know what women like you think about the Booklet when going through it. This is so that when we try to use it here at [Health center name] as a tool for reflection for women, the Booklet reflects the experiences and inputs of women themselves. Please be honest with sharing your thoughts because we will take what you say today to help make the Booklet better.

Today, I would like for you and me to walk through this Booklet together, section-by-section, and see how you feel. Each section is about some aspect of women's lives. We'll take five minutes of silence for you to simply go through the section, read, and fill out what's interesting to you. There's no right or wrong way to do it. Then, we'll chat for about five minutes after about what you liked, what stuck out to you, and what parts you filled out.

Do you have any questions before we begin?

Okay. Let's go ahead and start with the first section, "Knowing Myself...My Strengths, Weaknesses, and Skills".

QUESTIONS (to be used for all six sections)
1. How did you feel about this section as a whole?
2. What stood out to you about this section?
   PROBE: Was there anything you didn't like, or that bothered you?
   PROBE: Was there anything that you liked or found interesting?
3. How might you use what was covered in this section in your life?
4. Tell us about the parts of this section that you filled out.
   PROBE: Think about why you filled it out. Was it fun? Interesting? Something you genuinely wanted to think about for yourself? Etc.
5. Tell us about the parts of this section that you didn't fill out, or just skipped altogether.
   PROBE: Think about why you skipped it. Was it too long? Confusing? Boring? Something you didn't care about? Etc.

SECTIONS
*Knowing Myself...My Strengths, Weaknesses, and Skills*
*Taking Care of Myself*
*Supporting Myself*
*Being Myself...My Values, My Beliefs*
*Loving Myself...My Essence, My Relationships*

CLOSING QUESTION (after all six sections have been discussed)

1. Now that we've gone through the whole booklet, do you have final or overall thoughts? Anything that you haven't had a chance to share yet?
2. Would you recommend this booklet to a friend or family member? Why, or why not?

Thank you so much for spending your time with me today. As a thank you for your thoughts, you will receive a [compensation]. I appreciate it!

### 3. User Testing Question Guide (FOCUS GROUP)

*As a reminder, we recommend that this focus group be conducted during the time of an already scheduled group visit (e.g. the seventh session of an eight-week group), so as to maximize clients who have been participating in programming based on the booklet and/or have been using the booklet themselves.*

INTRODUCTION

Hello everyone, thank you for taking the time to come talk to us today about the *Wonderful Journey* booklet.

[Introduce self]

Today, we're here because we want to know how this booklet is being used and if it's been helpful for people. [Client contact] let us know that you all have been using the booklet in this group, so we wanted to come and chat with you all about what you thought about it. Please be honest with us, because we can use it to improve the booklet and how it is shared with women like you throughout Hawai'i. What you tell us today will be so valuable.

QUESTIONS

1. To start, it would be great to hear from you all how this booklet is used in this group. We have a general idea from [clinic contact], but we would love to hear what you all think.
   PROBE: Do you guys play any games? Discuss the topics from the booklet? Share your personal ideas/experiences?
2. In what ways do you use the booklet in your daily life (if at all)?
   PROBE: Has it changed your thoughts on certain topics?
   PROBE: How has it supported you in making decisions?
   PROBE: How has it helped in terms of family planning?
3. How does this booklet compare to other services or programs you participate in at [name of health center]?
4. What do you wish were different about this booklet? Or if you can add to or change anything about this booklet, what would you?
   PROBE: Change to formatting, pictures, language, content, health concerns, life skills that they might like to see.
5. What's your favorite thing about this booklet?

That's about all the questions we have. Does anyone have any final or overall thoughts, maybe something they didn't get a chance to share?

Well, thank you for your time, we truly appreciate it and will use what we heard here to improve the booklet, as well as help other clinics in using the booklet effectively.

## 4. User Testing Question Guide (SEMI-STRUCTURED INTERVIEW)

*As a reminder, we recommend that this interview be conducted during the time of a return patient, so as to maximize clients who have been participating in programming based on the booklet and/or have been using the booklet themselves.*

INTRODUCTION
Hello, thank you for taking the time to come talk to me today about the *Wonderful Journey* booklet.

[Introduce self]

Today, I'm here because I want to know how this booklet is being used, and if it's been helpful for people. Please be honest with me, because I can use it to improve the booklet and how it is shared with women like you throughout Hawai'i. What you tell me today will be so valuable.

QUESTIONS

1. To start, it would be great to hear from you how this booklet is used in your visits to [name of health center]. I have a general idea from [clinic contact], but I would love to hear what you all think. PROBE: Do you play any games? Discuss the topics from the booklet? Share your personal ideas/experiences?
2. In what ways do you use the booklet in your daily life (if at all)?
   PROBE: Has it changed your thoughts on certain topics?
   PROBE: How has it supported you in making decisions?
   PROBE: How has it helped in terms of family planning?
3. How does this booklet compare to other services or programs you participate in at [name of health center]?
4. What do you wish were different about this booklet? Or if you can add to or change anything about this booklet, what would you?
   PROBE: Change to formatting, pictures, language, content, health concerns, life skills that they might like to see.
5. What's your favorite thing about this booklet?

That's about all the questions we have. Do you have any final or overall thoughts, maybe something you didn't get a chance to share?

Well, thank you for your time, we truly appreciate it and will use what we heard here to improve the booklet, as well as help other clinics in using the booklet effectively.

### *E. Technical Guidance Notes on Qualitative and Quantitative Data Collection and Analysis*

Qualitative Data Collection

*Semi-structured Interviews*

Characteristics

- The interviewer and respondents engage in a one-on-one interview.
- The interviewer uses an interview guide. This is a list of questions (similar to suggested guides in **Appendix D**) and topics that need to be covered during the conversation, usually in a particular order.
- The interviewer uses the guide, but has the flexibility to follow the natural flow in the conversation that may stray from the guide when he/she feels this is appropriate.

When to Use

- Semi-structured interviewing is best for when there will likely not be more than one opportunity to interview someone, or when you will be sending several interviewers out into the field to collect data. Compared to focus groups, it allows you to get a deeper perspective from an individual (Wengraf, 2001).
- The semi-structured interview guide provides a clear set of instructions for interviewers and seeks to elicit data that is comparable and reliably captured. At the same time, it offers the flexibility to stray and identify novel aspects of concept. This can inform a re-design or improvement of question guides for future interviews.
- Semi-structured interviews are often preceded by observation, informal and/or unstructured interviewing in order to allow the researchers to develop a keen understanding of the topic of interest which is helpful for developing relevant and meaningful semi-structured questions.

Documentation

- Typically, interviewer will have a paper-based interview guide that they could follow. Since semi-structured interviews often contain open-ended questions and discussions may diverge from the interview guide, it's generally best to audio record interviews and transcribe them later.
- However, often audio recording may not be appropriate or the interviewee might not be comfortable. While it is possible to try to jot notes to capture answers, it is difficult to focus on conducting an interview and jotting notes simultaneously. If audio recording is not permitted, consider a notetaker.

*Focus Groups*

Characteristics

- The focus group facilitator leads a conversation with a group of individuals, ideally no more than 8-10 people (Wengraf, 2001).
- The interviewer uses a focus group guide. This is a list of questions (similar to suggested guides in **Appendix D**) and topics that should be covered during the conversation.
- The interviewer uses the guide, but has the flexibility to follow natural flow in the conversation that may stray from the guide when he/she feels this is appropriate.

- Focus group organizers should be mindful of the potential power dynamics that may arise among participants. Also, focus groups require an individual who is comfortable and competent with facilitation. It is important to remain mindful of participants who are overbearing, quiet, steers the conversation off-topic, etc.

When to Use

- Focus groups are most useful when you want to learn from many respondents at once, and/or when you are interested in exploring the topic within the context of a social group interaction.
- The focus group guide provides a clear set of instructions for the facilitator and seeks to elicit data that is comparable and reliably captured. At the same time, it offers the flexibility to stray and identify novel aspects of concept. This can inform a re-design or improvement of question guides for future interviews.

Documentation

- Typically, the facilitator will have a paper-based focus group guide that they could follow. Since focus groups often contain open-ended questions and discussions may diverge from the guide, it's generally best to audio record focus groups and transcribe them later. This is even more important in focus groups than interviews, because the facilitator has so much work to do.

- However, often audio recording may not be appropriate or the participants might not be comfortable. While it is possible to try to jot notes to capture answers, it is difficult to focus on conducting an interview and jotting notes simultaneously. If audio recording is not permitted, consider a notetaker.

<u>Qualitative Data Analysis</u>

In the body of the evaluation report, we recommend Consensual Qualitative Research (CQR) for its flexibility and relative ease of use for formative qualitative research. If a CQR approach is employed, we recommend the development and coding of domains to be completed independently by individual evaluators, and then brought together to distill core ideas. Then, categories can be developed to describe consistencies across cases (i.e., cross-analysis). For further information, consult Hill et al., 1997.

Another common approach to qualitative analysis is the constant comparison method, which has the aim of developing a "grounded theory". Flexible guidelines for coding data for engaging in this analysis include open coding (the initial breakdown and examination of data), axial coding (putting the data back together in new ways after coding, by making connections between categories utilizing a coding paradigm), and selective coding (identifying the core category, and systematically relating it to other categories thereby validating those relationships). Throughout the process of constant comparison, insights that are gleaned during an ongoing analysis process inform future stages of data collection. This process continues until "saturation" – when a strong understanding of the phenomenon is ascertained. For more information, consult Dye et al., 2000.

Finally, a third qualitative analysis approach warranting consideration is the framework approach, in which data analysis occurs after data collection and management already happens. The goal of the framework approach is to facilitate interpretation – involving thematic analysis, typologies, and finally explanatory analyses. For more information, consult Ritchie et al., 2003.

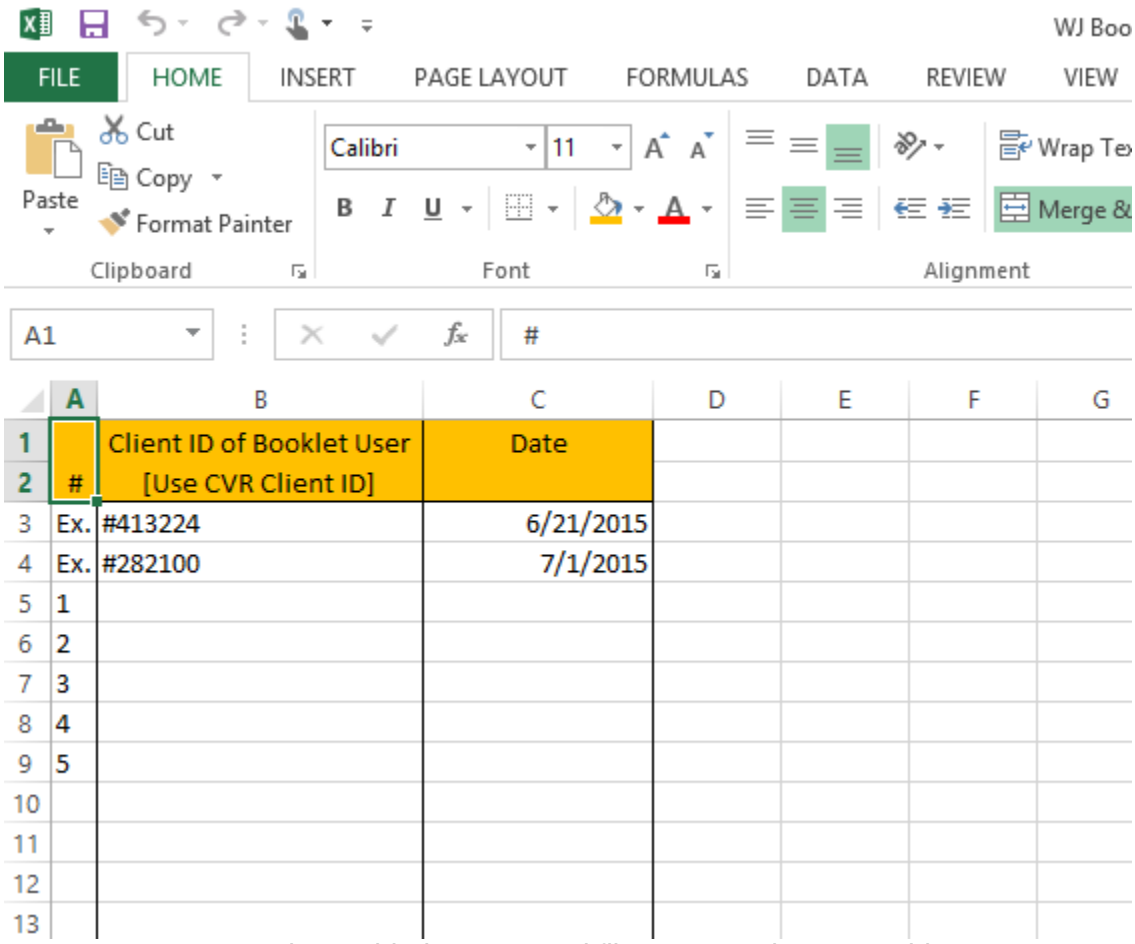
Quantitative Data Analysis

For quantitative data analysis, we recommend the tabulation of cross-sectional and longitudinal univariate (descriptive) and bivariate statistics to capture "effectiveness" – the Booklet's impact on RLP creation and outcomes captured by the CVR. The table below describes potential bivariate analyses.

| **Independent Variable (X)** | **Data Type** | **Dependent Variable (Y)** | **Data Type** | **Potential Analyses** |
|---|---|---|---|---|
| Booklet Receipt | Dichotomous | Reproductive Life Plan (RLP) | Dichotomous | Chi-square, Fisher's exact test |
| | | Pregnancy Intention | Dichotomous | Chi-square, Fisher's exact test |
| | | Pregnancy Risk Factors: Tobacco, Alcohol Use, Drug Use, DV, Depression | Dichotomous | Chi-square, Fisher's exact test |
| | | Pregnancy Risk Factor: BMI | Continuous | ANOVA |
| | | Pregnancy Test Outcome | Dichotomous | Chi-square, Fisher's exact test |
| | | Emergency Contraceptive provided | Dichotomous | Chi-square, Fisher's exact test |
| | | STD Tests: Chlamydia, Chlamydia re-screening, Gonorrhea, Gonorrhea re-screening, HIV-Confidential, Syphilis | Categorical | Chi-square, Fisher's exact test |
| | | STD Treatments: Chlamydia, Gonorrhea, Syphilis | Categorical | Chi-square, Fisher's exact test |
| | | Procedures: Cervical/Diaphrgm fitting, IUD insertion, IUD removal, implant insertion, implant removal | Categorical | Chi-square, Fisher's exact test |
| | | Health Education Counseling | Categorical | Chi-square, Fisher's exact test |
| | | Condom Use | Dichotomous | Chi-square, Fisher's exact test |
| | | Contraceptive Method at End of Visit | Categorical | Chi-square, Fisher's exact test |

### *F. Data Shells / Data Collection Tools*

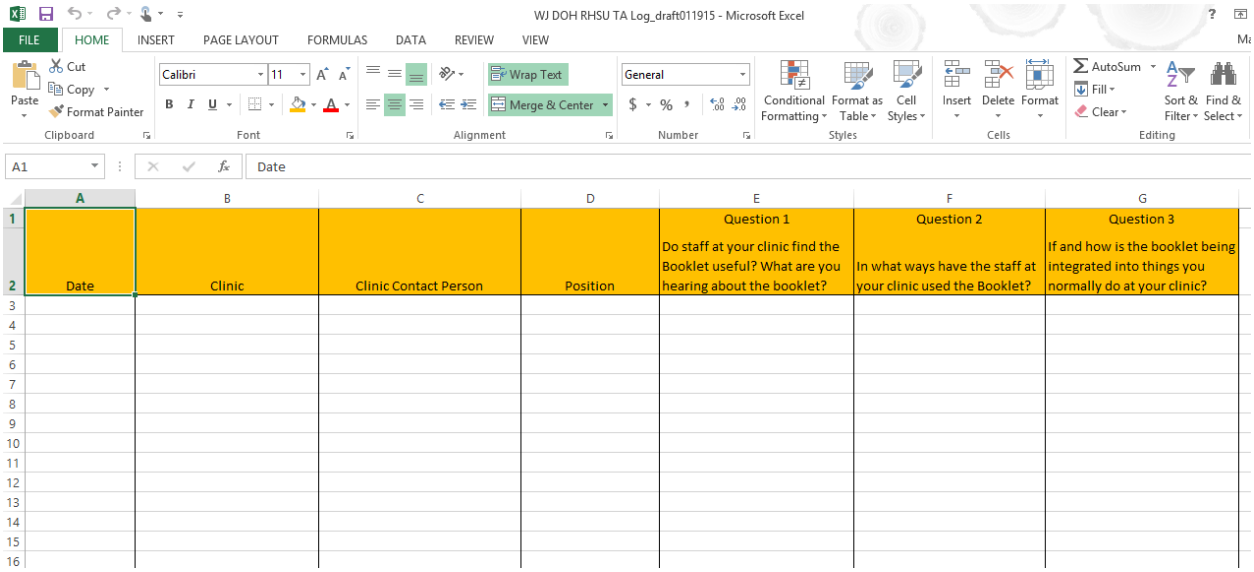
#### 1. Department of Health Reproductive Health Services Unit Technical Assistance and Clinic Feedback Log




| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | | Client ID of Booklet User | Date | | | | |
| 2 | # | [Use CVR Client ID] | | | | | |
| 3 | Ex. | #413224 | 6/21/2015 | | | | |
| 4 | Ex. | #282100 | 7/1/2015 | | | | |
| 5 | 1 | | | | | | |
| 6 | 2 | | | | | | |
| 7 | 3 | | | | | | |
| 8 | 4 | | | | | | |
| 9 | 5 | | | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |
| 12 | | | | | | | |
| 13 | | | | | | | |

Note: The DOH RHSU TA Log is provided as an Excel file as a supplement to this report.

## 2. Booklet Implementer Log




| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | | | | | Question 1 | Question 2 | Question 3 |
| 2 | Date | Clinic | Clinic Contact Person | Position | Do staff at your clinic find the Booklet useful? What are you hearing about the booklet? | In what ways have the staff at your clinic used the Booklet? | If and how is the booklet being integrated into things you normally do at your clinic? |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
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| 12 | | | | | | | |
| 13 | | | | | | | |
| 14 | | | | | | | |
| 15 | | | | | | | |
| 16 | | | | | | | |

Note: The Booklet Implementer Log is provided as an Excel file as a supplement to this report.

**Question 1:** This question will provide information about adoption, and the extent to which Booklet implementers are willing to use the booklet in practice.

**Question 2:** This question will provide information about the ways in which the Booklet is being implemented at each clinic.

**Question 3:** This question will provide information about the potential for the Booklet to be maintained over time.

### *G. Preliminary Considerations for Outcome Evaluation*

As described in the report, we have focused our efforts on articulating a formative evaluation framework for this booklet, in order to ascertain if the booklet is successful in facilitating the creation of RLPs. Once this is established, it is then possible to consider its link to long-term health measures, e.g., improved birth outcomes. However, we recognize that assessing impact is an important priority for DOH. We offer preliminary considerations for outcome evaluation, which can serve as the basis for the development of a logic model and ultimate evaluation strategy for *Wonderful Journey* at a later time. Of course, the components and measures in the outcome evaluation cannot be fully articulated until the implementation approach is solidified and, ideally, after the formative evaluation is completed.

We propose the following: (1) build an outcome logic model, including indicators, (2) discuss incorporating other relevant databases into the analysis, and (3) vetting the proposed outcome evaluation strategy with stakeholders, especially booklet implementers.

<u>Build outcome logic model</u>
Outcome evaluation development should begin with a consultative process involving discussion among DOH staff and booklet implementers to define program:

1. *Inputs*: people, organizations, and resources that are involved or participate in booklet.
2. *Activities*: specific actions that constitute program delivery to its target population. This will be largely informed by what is learned from the formative evaluation.
3. *Outputs*: the indicators that reflect that activities are taking place with the target population.
4. *Short-term outcomes*: logically caused by activities (generally, in health behavior change, this might refer to knowledge or conceptual changes).
5. *Long-term outcomes*: long-term intended impacts if short-term outcomes are fulfilled (generally, in health behavior change, this might refer to actual behaviors or actions). This is arguably the most important aspect of the logic model because it will largely determine what indicators you will be assessing in order to determine program effectiveness. Thus, careful consideration and a clear decision must be made, regarding whether the long-term health outcome should be “decrease unplanned pregnancy rates”, “improve birth outcomes”, “increase birth spacing”, etc. – even though they are all related to each other, this will make a difference in measurement and success of the evaluation. We recommend aiming to align these long-term outcomes with performance indicators from the upcoming 2015 Title V Needs Assessment Priorities and/or other identified MCHB identified priorities.

Ideally, the program’s “impact” should be agreed upon first before other elements in the model – this could be a lofty vision of what might ideally happen if program implementation occurs as intended. Outcomes should then be designated that would secure the result, and organized into short and long-term. Then, activities should be brainstormed that logically link to those short-term outcomes. Activities should be organized relative to single or multiple strategies. For given strategies/activities, describe the resources or inputs needed. From these activities, cite which outputs might be reasonable to capture.

<u>Discuss rationale and incorporate other relevant implementation sites and their corresponding databases</u>

During our January site visit, we discussed including the booklet in alternate implementation sites and including their corresponding databases to be able to more effectively track impact of

the booklet, given clinic realities. While we recognize the value of this suggestion, as described above, we have limited our analysis and recommendations to the original proposed route of delivery via clinics receiving Title X funding only. Discussions pertinent to which funding source to include would be prudent in the next phase of evaluation (see ***Recommendations:*** **Booklet Improvement).**

It is also critical to determine if alternate sites would either be included *before* the formative evaluation, or *after* the formative evaluation is complete after interpreting those results. This will impact whether or not you would include the additional data sources into the formative logic model or the outcome logic model.

Additional funding sources / routes of Booklet delivery that merit consideration include:

- Perinatal Support Services (PSS Data Collection Form)
- Home Visiting Services
- Clinic Electronic Health Records (i.e., a chart audit)

## Evaluator Contact Information

This evaluation plan was developed in January 2015 through the Harvard-CDC Program Evaluation Practicum. For any further questions, concerns, or considerations regarding this evaluation, please contact either or both of the student evaluators below.

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